STATE OF VERMONT
LEGISLATIVE JOINT FISCAL OFFICE
LEGISLATIVE COUNCIL
COMMISSION ON HEALTH CARE REFORM
DEPARTMENT OF VERMONT HEALTH ACCESS
DEPARTMENT OF BANKING, INSURANCE, SECURITIES & HEALTH CARE ADMINISTRATION

The 2011 Legislative Session: Implementation of the federal Affordable Care Act (ACA) and Vermont's Health Care Reform Initiatives

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The purpose of this issue brief is to highlight many of the health care and human services related issues with which the legislature and the executive branch may be confronted during the upcoming legislative session. We recognize that both the House Health Care and Senate Health & Welfare committees will have new chairs, as well as many new committee members, and that the legislative priorities and agendas have not yet been set. In addition, the new Governor will be recruiting a new leadership team. But in the midst of these transitions, it is important to note that the executive and legislative branches have historically shared the goals of increasing access, containing costs, and increasing quality. Over the past several years, legislative and administration staff have worked in a collaborative, non-partisan manner on a variety of health and health care reform related issues, including interpreting state and federal laws, communicating jointly regarding federal issues, developing consensus budget and enrollment projections, and estimating the impacts of proposed state and federal reforms.

Health care spending is projected to increase by $1 billion during the three-year period from 2009 to 2012.[1] While Vermont has a long history of health care reform efforts, since 2004 there has been a renewed push for major reforms. Catamount Health, the Blueprint for Health, the acceleration of health information technology (HIT) implementation, and operation of a health information exchange (HIE) are just some of the programs, initiatives, and policies Vermont has enacted toward meeting the goals of increasing access, containing costs, and increasing quality. The many health care reforms passed in the federal Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA")[2] also created new responsibilities, issues, and opportunities for the state.

While this list is not exhaustive, it is meant to highlight both the breadth and complexity of the issues that may be before the committees of jurisdiction, the legislature as whole, and the new administration. These issues include the following:

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[1] According to the BISHCA Vermont Health Care Expenditure Analysis, total resident health care spending was projected to be $4.9 billion in 2009 and $5.9 billion in 2012. There is a two year lag on the data, so the report only has actual expenditures through 2008.

[2] The Patient Protection and Affordable Care Act was signed by President Obama on March 23, 2010. Many have begun to abbreviate the name to the Affordable Care Act or ACA. It was accompanied by a companion act called The Health Care Reconciliation Act of 2010, which was signed on March 30, 2010.

- Establishment of health insurance exchanges
- ACA-required insurance market reforms
- ACA Medicaid expansion impacts on Vermont
- Maintenance of eligibility/effort provisions
- Act 128 of 2010 health care system design options
- Act 128 of 2010 health care workforce study follow-up
- Specific Medicaid issues
- Projected Medicaid program deficits
- Catamount sustainability concerns
- Payment reform initiatives
- Blueprint for Health expansion
- Short-term health care cost controls
- Health information technology issues
- Autism spectrum disorder mandate and impact study
- Pharmacy issues
- Long-term care issues and initiatives
- DCF modernization status update
- Prevention and wellness efforts

The Affordable Care Act of 2010 (aka "Federal Health Care Reform" or "ACA")

- Health insurance exchanges – The Affordable Care Act (ACA) directs states to establish and begin operation of a health benefit exchange no later than January 1, 2014. The exchange will be a central point of access for individuals and small businesses (with 50 to 100 employees[3]) to acquire health care coverage. While 2014 seems far away, the federal government is emphasizing the importance of acting promptly in order to have an exchange in place by the end of 2013; if the state does not design and implement an exchange by the deadline , the U.S. Department of Health and Human Services (HHS) will design and implement one for residents of the state. The Vermont Agency of Human Services (AHS), in collaboration with the Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), has already received a $1 million grant from the federal government to start the planning process, but will have to meet several benchmarks to show that progress is being made in order to receive future federal dollars toward implementing the exchange. One of those benchmarks is the passage of legislation this session concerning exchange planning and implementation. The next round of federal grant opportunities will be in May 2011, which means that this and other benchmarks would have to be met before May if the state wanted to maximize the federal grant funds available. If the legislature chooses to design a state exchange, there are many important planning decisions to be made, including whether a state agency will operate the exchange or whether the state would create a private non-profit entity to operate the exchange. The state may also decide to be part of a regional multi-state exchange. However, under current federal law, if the state chooses to do none of these things, the federal government will operate the exchange in Vermont. Other governance issues which may arise include benefit plan choices and transparency, consumer outreach and education, a single application for coverage, and access to federal subsidies and tax credits. How the exchange is ultimately designed will be at the core of determining the future costs and financing of the system. It should also be acknowledged that there is the potential for overlap between decisions to be made regarding the planning of an exchange and the Act 128 study design options (addressed below) about which the legislature and administration may want to be aware .

- Insurance market reforms – The ACA also instituted many insurance market reforms that involve compliance and regulatory issues. Examples include whether the state should combine the individual and small group markets (approximately 125,000 beneficiaries); what to do with the so-called "Safety Net" population; and the future role of the association market, which currently includes approximately 80,000 Vermonters. The one-year, $1 million exchange planning grant received by AHS/BISHCA includes funds for a contract with a

[3] States have the option to define a "small business" as no more than 100 employees or no more than 50 employees until 2016. Vermont health insurance law currently defines a small employer as one who employs between one and 50 employees. One of the decisions for the state is whether to increase our definition to 100 employees before 2016.

consulting organization(s) to help advise on and model these issues. The consultants' work will play an integral role in helping Vermont to meet the benchmarks mentioned above.

- Medicaid expansion – The ACA also expanded Medicaid. While these expansions will not take effect until 2014, any decisions concerning Medicaid, whether budgetary or policy-related, will require a thorough understanding and consideration of what is coming down the pipeline in 2014. While Vermont already covers most of the new federal expansion populations, the ACA also instituted an insurance mandate that requires all individuals to have "minimum essential coverage." This will likely result in additional growth of the state's Medicaid rolls, as approximately half of Vermont's uninsured residents are eligible for existing Medicaid programs but are not enrolled (often referred to as the "woodwork effect"). However, the income eligible criteria will also change and it is still unclear what will be the overall impacts of the ACA on Vermont's Medicaid program. The Legislative Joint Fiscal Office (JFO) and the Department of Vermont Health Access (DVHA) are working collaboratively to estimate the impact of the ACA's Medicaid changes on Vermont.

- Medicaid Maintenance of Eligibility/Effort (MOE) – Both the federal American Recovery and Reinvestment Act of 2009 and the ACA have MOE provisions that prohibit the states from instituting Medicaid eligibility and enrollment policies that are more restrictive than those in effect prior to enactment of each act until 2014. This includes bans on tightening financial eligibility and increasing premiums. However, the state can receive some exemptions from MOE if it certifies that it is experiencing or projecting a budget deficit in the following state fiscal year (SFY). States can make this certification as early as December 1, 2010. A budget gap of $112 million is currently projected for SFY 2012, of which the Medicaid deficit is projected to be between $30 to $40 million, and current trend estimates indicate additional funds may needed to cover increases to caseload and utilization.

Act 128 of 2010

- Health Care Design Options – Act 128 directs for the hiring of a consultant to design three health system options: a single payer system, a public option, and a third design to be determined by the consultant. Act 128 requires the consultant to consider methods of maximizing federal funds, including funds available for the health insurance exchange. The Commission hired a team lead by Dr. William Hsiao, a professor of economics at the Harvard School of Public Health. The act directs the consultant to release a draft report in January for public comment, followed by the submission of a final report to the legislature in February. We anticipate a high level of interest in the final report from legislators, the administration, and the public.

- Provider Payment Reform – Reform of the current fee-for-service system used to pay health care providers is an integral part of the broader health care reform discussion. Act 128 created a Director of Payment Reform within DVHA who will design payment reform pilot projects and present these ideas to the House Committee on Health Care and Senate Committee on Health and Welfare by February 1, 2011. One such pilot project must be operational by January 1, 2012, with at least two more underway by July 1, 2012. The committees likely will wish to understand the driving principles behind the concepts of payment reform and how the director's recommendations interface with the health system design options proposed by Dr. Hsiao and his team.

- Blueprint for Health expansion – Act 128 included initiatives to accelerate the expansion of the Blueprint for Health, including a requirement that DVHA expand the Blueprint to at least two primary care practices in each hospital service area by July 2011 and to all primary care practices who wish to participate by October 1, 2013. This expansion is strongly dependent upon Vermont receiving a much-anticipated Centers for Medicare & Medicaid Services (CMS) demonstration grant to support Medicare participation in the Blueprint and funding for community health teams.

- Health Care Workforce – Access to care requires that Vermont have an adequate and well-trained workforce including not only physicians, but a variety of other health care professionals. The ACA has a number of workforce initiatives that will impact Vermont and Act 128 created a Vermont Primary Care Workforce Development Committee, whose interim study is due by November 15, 2010.

Medicaid and Long Term Care Issues

- Global Commitment Waiver Renewal – The Global Commitment to Health, the state's Section 1115 Medicaid waiver, is up for renewal with CMS within HHS. Lawyers for the federal government raised some last minute concerns, and at the time of the writing of this brief, Vermont is currently being renewed on a month-to-month basis as the details are being worked out. Depending upon the outcome of the finalized renewal language, potential legislative action may be required to be in compliance with federal requirements. At the very least, the waiver renewal is an issue about which the legislature will need to be aware as any changes could have potential fiscal implications.

- Medicaid Minutiae – In addition to a projected $30 to $40 million Medicaid deficit, there are many technical aspects that need to be addressed concerning Medicaid and Catamount Health policies, such as unresolved Catamount eligibility issues, indexing of Catamount premiums, retroactive eligibility in VHAP, and children's palliative care. It is also highly likely that the Governor's recommended Medicaid budget proposal will contain many complex initiatives and members of the committees of jurisdiction likely will wish to have a thorough understanding of Medicaid financing and policy.

- Catamount Sustainability – The long-term sustainability of the Catamount Fund has been a concern since the fund's creation[4]. As of September 2010, approximately 12,500 people were enrolled in the Catamount Health plans offered by Blue Cross Blue Shield of Vermont (BCBSVT) and MVP Health Care (MVP), of whom more than 10,000 receive premium assistance from the state, paid from the Catamount Fund.[5] Expenditures are exceeding revenues and, as a result, in addition to making minor changes to the benefits under Catamount Health (by increasing deductibles and co-pays), the legislature also appropriated $7 million in general fund dollars to cover Catamount expenses for SFY 2011. The Catamount Fund shortfall for SFY 2012 is likely to be even larger, and the legislature will once again be faced with tackling this issue, whether by appropriating additional general fund dollars, reducing benefits, or other measures. Another related issue is the number of Catamount plan options going forward. Recent approval of new premium rates for the two participating carriers set MVP's monthly premium $113 higher than BCBSVT's, a differential that would be paid by the beneficiary (if receiving premium assistance) in addition to their subsidized premium. This will likely result in many members disenrolling from the MVP Catamount offering. In addition, CMS is requiring states to provide transitions plans for all populations above 138% of the federal poverty level by 2012. This will require legislators to consider the future of Catamount, including whether and/or how to include Catamount in the insurance exchange.

- Long Term Care – In the House, long-term care is generally addressed by the Committee on Human Services; in the Senate, it is the purview of the Committee on Health & Welfare, which has jurisdiction over the areas of both health and human services. There are many long-term care-related initiatives, grants, and projects underway as part of state and federal health care reform efforts about which legislators likely will wish to be informed, such as an initiative Vermont is pursuing to serve as the Medicare plan for individuals eligible for both Medicare and Medicaid (dual-eligibles).

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[4] When the Catamount Fund was created, it was anticipated that sustainability could be problem as early as 2010.

[5] As of September 2010, another 729 people were enrolled in Employer Sponsored Insurance Assistance (ESIA). These beneficiaries also receive premium assistance paid from the Catamount Fund.

Other System-wide Health Reforms & Issues

- Health Information technology – Health information technology (HIT) is a major component of health care reform. Recent federal legislation has provided significantly enhanced funding opportunities for both electronic medical records (EMRs) and for secure health information exchange (HIE). These opportunities will enable Vermont to leverage the Vermont HIT Fund, currently estimated at $9 million, since many of the federal programs require state matching funds for which the HIT fund can be used. It is important for the legislature to keep abreast of the evolving and expanding scope of the state's HIT plan. The rapid spread of HIT, the exchange of information with mental health providers, and the exchange of information across state lines create a new set of privacy and security issues which may also need to be addressed by the legislature. While Vermont is recognized as a leader for our progress toward implementing a statewide HIT/HIE, the state still has more work to do in this area.

- Autism Spectrum Disorder – Act 127 of 2010 mandated coverage for the diagnosis and treatment of autism spectrum disorders (ASD) for children between the ages of 18 months and 6 years old (or entering the first grade, whichever is earlier). This mandate takes effect July 1, 2011. The act requires AHS, the Agency of Administration, and the Department of Education to examine the feasibility and impact of expanding coverage to all children under age 18, as well as to assess the availability of providers who treat children with ASD, and to report to the committees of jurisdiction by January 15, 2011. The agencies and the department must also estimate the amount of savings and avoided costs to be realized by the state as a result of the coverage mandate and include this in their SFY 2012 budget proposal and report on it to the committees of jurisdiction by February 15, 2011. If the savings and avoided costs report or the committees' own findings indicate that there will not be sufficient funds to offset the state's share of the expenditures, the act expresses the legislature's intent to consider whether or not to allow the coverage mandate to be implemented.

- Pharmaceutical Pricing Changes in Medicaid – CMS is working with states to modify the pharmaceutical pricing methodology from a formula based on Average Wholesale Price (AWP) for pharmaceuticals paid by Medicaid. This change was instituted because a federal court decision determined that companies had fraudulently set the AWP. Once CMS has determined appropriate methods available for use by the state, members may wish to understand the fiscal implications of the pricing changes and their impacts on consumers, pharmacists, and others.

- Pharmaceutical Rebates – The ACA modified the amount the federal government receives in rebates from pharmaceutical manufacturers for certain pharmaceuticals purchased by Medicaid, which in turn affects the amount of the rebates the state receives. This change will result in approximately $4.2 million (general fund) in lost rebates for SFY 2012. Last year's state budget directed DVHA to aggressively pursue the state's supplemental rebates to offset this loss. The legislature and administration may wish to explore the inherent tension between the state's generic preference laws and the aggressive pursuit of supplemental rebates on brand name drugs. It is also possible that additional offsets to the lost rebates could be found through increased aggressiveness in purchasing generics.

- Short-term Health Care Cost Control – The legislature has established short-term targets that support the Commissioner of BISHCA placing limits on the increase in net patient revenues for hospitals for state fiscal years 2011 and 2012. Fiscal pressures on state, local, and employer budgets have created a need to explore short-term approaches to controlling health care costs while longer term reforms are being designed and implemented.

- DCF Modernization – The Department for Children and Families (DCF), which does eligibility and enrollment for the state health care programs, has been implementing a new, "modernized" eligibility system. This system includes on-line applications and a telephone call center. Recently, DCF has not been able to meet its statutory deadlines for application processing. While the agency is working on faster processing times, members may want more

information about the delays and their impact on enrollment in the state's health care programs.

- The Vermont State Hospital – While the Department of Mental Health is involved in ongoing discussions about how to replace the functions of the Vermont State Hospital, no plans have been finalized. Currently, very little of the funding for VSH is matched with federal funds. In the 2010 capital bill, the legislature set aside $10 million in state funds that were freed up as a result of the enhanced FMAP extension in the ARRA. The VSH replacement options will likely consider leveraging federal matching funds.

- Prevention – Legislators may want to be kept informed about ongoing prevention programs as well as recent federal grant funding opportunities included in the ACA.

- AHS IT System Replacement – The Agency of Human Services health care eligibility system and the DVHA Medicaid Management Information System (MMIS) – the claims processing system – are old, and as a result it is difficult for AHS and DVHA to make changes their systems or produce data reports. AHS/DVHA have issued requests for proposals (RFPs) to replace these systems, which are planned to be operational by January 2013. Once these new systems become operational, they are anticipated to be able to provide timely data to the legislature and the administration to assist in making informed policy decisions.

For more information contact:

Vermont Legislative Joint Fiscal Office
Nolan Langweil, Fiscal Analyst nlangweil@leg.state.vt.us
Stephen Klein, Chief Fiscal Officer sklein@leg.state.vt.us
Stephanie Barrett, Associate Fiscal Officer sbarrett@leg.state.vt.us

Vermont Legislative Council
Robin Lunge, Legislative Counsel rlunge@leg.state.vt.us
Jennifer Carbee, Legislative Counsel jcarbee@leg.state.vt.us

The Commission on Health Care Reform
Jim Hester, Executive Director jhester@leg.state.vt.us

Department of Vermont Health Care Access
Susan Besio, Commissioner susan.besio@ahs.state.vt.us
Hunt Blair, Deputy Director, Division of Health Care Reform hunt.blair@ahs.state.vt.us
Steve Maier, HCR-HIT Integration Manager steven.maier@ahs.state.vt.us
Betsy Forrest, Health Care Reform Project Director Betsy.forrest@ahs.state.vt.us

Department of Banking, Insurance, Securities and Health Care Administration
Christine Oliver, Deputy Commission Christine.oliver@state.vt.us
Rebecca Heintz, Associate Legal Counsel Rebecca.heintz@state.vt.us